ACRONYMS & GLOSSARY

SECTION S

Frequently Used Acronyms

A

AAA - Area Agency on Aging
ADA - Americans with Disabilities Act of 1990
ADL - Activities of Daily Living
ADRC - Aging & Disability Resource Center
AEP - Annual Coordinated Election Period
ALJ - Administrative Law Judge
ALS - Amyotrophic Lateral Sclerosis
AOA - Administration on Aging

B

BBA - Balanced Budget Act or 1997
BHA - Bureau of Hearings and Appeals

C

CDC - Centers for Disease Control
CHOICE - Community and Home Options to Institutional Care for the Elderly and Disabled
COB - Coordination of Benefits
CMS - Centers for Medicare and Medicaid Services
COBRA - Consolidated Omnibus Budget Reconciliation Act of 1985
CTM - Complaints Tracking Module

D

DC - Diagnostic Code
DFR - Department of Family Resources
DHHS - Department of Health & Human Services
DME - Durable Medical Equipment
DMEMAC - Durable Medical Equipment Medicare Administrative Contractor
DMEPOS - Durable Medical Equipment Prosthetic, Orthotics & Supplies
DOD - Department of Defense
DOE - Date of Entitlement
DOI - Department of Insurance
DOL– Department of Labor
DRG - Diagnosis Related Group
DVA - Department of Veteran Affairs
DWA - Disabled Working Aged
DWB - Disabled Widow's Benefits
DWI - Disabled Working Individual

E

EGHP - Employer Group Health Plan
EHR - Electronic Health Records
EOB - Explanation of Coverage
EOC - Evidence of Coverage
ERx - Electronic Prescription Prescribing
ESRD - End Stage Renal Disease

F

F&A - Fraud & Abuse
FAQ - Frequently Asked Question
FDA - Food & Drug Administration
FEHBP - Federal Employees Health Benefit Program
FFS - Fee-for-service
FPL - Federal Poverty Level
FQHC - Federally Qualified Health Center

G

GEP - General Enrollment Period
GHP - Group Health Plan

H

HHA - Home Health Agency
HHABN - Home Health Advanced Beneficiary Notice
HHS - (Dept.) Health & Human Services
HIB - Hospital Insurance Benefits (Part A)
HIC - Health Insurance Claim
HICN - Health Insurance Claim Number (Medicare Number)
HIPPA - Health Insurance Portability and Accountability Act of 1996
HMO - Health Maintenance Organization
HRSA - Health Resources & Services Administration

I

ICF - Intermediate Care Facility
ICHIA - Indiana Comprehensive Health Insurance Association
IDOI - Indiana Department of Insurance
IEP - Initial Enrollment Period
ILTCIP - Indiana Long Term Care Insurance Partnership
IRC - Inpatient Respite Care
IRE - Independent Review Entity
IWD - Individuals With Disablities

L

LGHP - Large Group Health Plan
LIS - Low Income Subsidy
LOS - Length of Stay
LRD - Lifetime Reserve Days
LTC - Long Term Care
LTF - Long Tern Care Facility

M

MA - Medicare Advantage
MAC - Medicare Appeals Council
MAC - Medicare Administrative Contractor
MAPD - Medicare Advantage Plan with Prescription Drug Coverage
MCO - Managed Care Organization
MDPDF - Medicare Prescription Drug Plan Finder
MFS - Medicare Fee Schedule
MIPPA - Medicare Improvements for Patients and Providers Act 0f 2008
MMA - Medicare Modernization Act of 2003
MSA - Medicare Savings Account
MSN - Medicare Summary Notice
MSP - Medicare Savings Programs
MSP - Medicare Secondary Payer

N

NAIC - National Association of Insurance Commissioners
NH - Nursing Home
NIA - National Institute on Aging
NIH - National Institute of Health
NMEP - National Medicare Education Program
NMTP - National Medicare Training Program

O

OBRA - Omnibus Budget Reconciliation Act of 1981/1987/1989/1990
OP - Outpatient
OPM - Office of Personnel Management
OPPS - Out Patient Prospective Payment System

P

PACE - Program of All-inclusive Care for the Elderly
PAS - Preadmission Screening
PBP - Plan Benefit Package
PDP - Prescription Drug Plan
PFFS - Private-Fee-for-Service (Plan)
PHR - Personal Health Record
PO - PACE Organization
POS - Point of Service
PPO - Preferred Provider Organization
PPS - Prospective Payment System
PRO - Peer Review Organization
PSA - Prostate Specific Antigen
PSO - Provider Sponsored Organization

Q

QDWI - Qualified Disabled and Working Individuals
QI - Qualified Individual
QIO - Quality Improvement Organization
QMB - Qualified Medicare Beneficiary
QWDI - Qualified Working Disabled Individual (aka QDWI)

R

RDF - Renal Dialysis Facility
RFP - Religious Fraternal Organization
RH - Rural Hospital
RHC - Rural Health Center
RRB - Railroad Retirement Board
RWJ - Robert Woods Foundation (ILTCIP)

S

SAA - State Administering Agency
SEP - Special Enrollment Period
SHIP - State Health Insurance Assistance Program
SLMB - Specified Low-Income Medicare Beneficiary
SMP - Senior Medicare Patrol
SNF - Skilled Nursing Facility
SNP - Special Needs Plan
SOP - Standard Operating Procedures
SPAP - State Pharmacy Assistance Programs
SS - Social Security
SSA - Social Security Administration
SSDI - Social Security Disability Insurance
SSI - Supplemental Security Income
SSN - Social Security Number

T

TFL - TRICARE For Life
TROOP - True Out-of-Pocket
TTY - Teletypewriter

V

VA - Department of Veterans Affairs
VDS - Voluntary Data Sharing

W

WA - Working Aged
WBT - Web Based Training

X

XMT - Transmit
XMTL - Transmittal
XVI - Title 16 Grants to States for Aid to the Aged, Blind or Disabled or Aid & Medical Assistance for the Medicare Beneficiary
XVIII - Title 18 Medicare Beneficiary
XX - Title 20 State operated home health care entitlement program
XXI - Title 21 State Child Health Program

Y

YOB - Year of Birth
YR - Year
YTD - Year to Date
YYYY - Year (i.e., mmddyyyy)

GLOSSARY

Term	Definition
A "TIER"	Is a specific list of drugs. Your plan may have several tiers, and your co-payment amount depends on which tier your drug is listed. Plans can choose their own tiers, so members should refer to their benefit booklet or contact the plan for more information.
ABUSE	A range of the following improper behaviors or billing practices including, but not limited to: Billing for a non-covered service; Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered); or Inappropriately allocating costs on a cost report
ACCESS	Your ability to get needed medical care and services.
ACCESSIBILITY OF SERVICES	Your ability to get medical care and services when you need them.
ACCESSORY DWELLING UNIT (ADU)	A separate housing arrangement within a single-family home. The ADU is a complete living unit and includes a private kitchen and bath.
ACCREDITATION	An evaluative process in which a healthcare organization undergoes an examination of its policies, procedures and performance by an external organization ("accrediting body") to ensure that it is meeting predetermined criteria. It usually involves both on- and off-site surveys.
ACT/LAW/STATUTE	Term for legislation that passed through Congress and was signed by the President or passed over his veto.

ACTIVITIES OF DAILY LIVING (ADL)	Activities you usually do during a normal day such as getting in and out of bed, dressing, bathing, eating, and using the bathroom.
ACTUAL CHARGE	The amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount Medicare approves. (See Approved Amount; Assignment.)
ADDITIONAL BENEFITS	Health care services not covered by Medicare and reductions in premiums or cost sharing for Medicare covered services. Additional benefits are specified by the MA Organization and are offered to Medicare beneficiaries at no additional premium. Those benefits must be at least equal in value to the adjusted excess amount calculated in the ACR. An excess amount is created when the average payment rate exceeds the adjusted community rate (as reduced by the actuarial value of coinsurance, co-payments, and deductibles under Parts A and B of Medicare). The excess amount is then adjusted for any contributions to a stabilization fund. The remainder is the adjusted excess, which will be used to pay for services not covered by Medicare and/or will be used to reduce charges otherwise allowed for Medicare-covered services. Additional benefits can be subject to cost sharing by plan enrollees. Additional benefits can also be different for each MA plan offered to Medicare beneficiaries.
ADMINISTRATIVE LAW JUDGE (ALJ)	A hearings officer who presides over appeal conflicts between providers of services, or beneficiaries, and Medicare contractors.
ADMISSION DATE	The date the patient was admitted for inpatient care, outpatient service, or start of care. For an admission notice for hospice care, enter the effective date of election of hospice benefits.
ADMITTING DIAGNOSIS CODE	Code indicating patient's diagnosis at admission.

ADMITTING PHYSICIAN	The doctor responsible for admitting a patient to a hospital or other inpatient health facility.
ADULT LIVING CARE FACILITY	To be used when billing services rendered at a residential care facility that houses beneficiaries who cannot live alone but who do not need around-the-clock skilled medical services. The facility services do not include a medical component (Program Memo B-98-28).
ADVANCE BENEFICIARY NOTICE (ABN)	A notice that a doctor or supplier should give a Medicare beneficiary when furnishing an item or service for which Medicare is expected to deny payment. If you do not get an ABN before you get the service from your doctor or supplier, and Medicare does not pay for it, then you probably do not have to pay for it. If the doctor or supplier does give you an ABN that you sign before you get the service, and Medicare does not pay for it, then you will have to pay your doctor or supplier for it. ABN's only apply if you are in the Original Medicare Plan. They do not apply if you are in a Medicare Managed Care Plan or Private Fee-for-Service Plan.
ADVANCE COVERAGE DECISION	A decision that your Private Fee-for-Service Plan makes on whether or not it will pay for a certain service.
ADVANCE DIRECTIVE (HEALTH CARE)	Written ahead of time, a health care advance directive is a written document that says how you want medical decisions to be made if you lose the ability to make decisions for yourself. A health care advance directive may include a Living Will and a Durable Power of Attorney for health care.
ADVOCATE	A person who gives you support or protects your rights.
AFFILIATED PROVIDER	A health care provider or facility that is paid by a health plan to give service to plan members.

AMBULANCE (AIR OR WATER)	An air or water vehicle specifically designed, equipped, and staffed for life saving and transporting the sick or injured.
AMBULANCE (LAND)	A land vehicle specifically designed, equipped, and staffed for life saving and transporting the sick or injured.
AMBULATORY CARE	All types of health services that do not require an overnight hospital stay.
AMBULATORY SURGICAL CENTER	A place other than a hospital that does outpatient surgery. At an ambulatory (in and out) surgery center, you may stay for only a few hours or for one night.
ANCILLARY SERVICES	Professional services by a hospital or other inpatient health program. These may include x-ray, drug, laboratory, or other services.
ANESTHESIA	Drugs that a person is given before surgery so he or she will not feel pain. Anesthesia should always be given by a doctor or a specially trained nurse.
APPEAL	An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services or payment for services you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if Medicare doesn't pay for an item or service you think you should be able to get. There is a specific process that your Medicare Advantage Plan or the Original Medicare Plan must use when you ask for an appeal.

APPEAL PROCESS	The process you use if you disagree with any decision about your health care services. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can have the initial Medicare decision reviewed again. If you are in the Original Medicare Plan, your appeal rights are on the back of the Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) that is mailed to you from a company that handles bills for Medicare. If you are in a Medicare managed care plan, you can file an appeal if your plan will not pay for, or does not allow or stops a service that you think should be covered or provided. The Medicare managed care plan must tell you in writing how to appeal. See your plan's membership materials or contact your plan for details about your Medicare appeal rights. (See also Organization Determination.)
APPROVED AMOUNT	The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."
AREA AGENCY ON AGING (AAA)	State and local programs that help older people plan and care for their life-long needs. These needs include adult day care, skilled nursing care/therapy, transportation, personal care, respite care, and meals.
ASSESSMENT	The gathering of information to rate or evaluate your health and needs, such as in a nursing home.
ASSETS	Treasury notes and bonds guaranteed by the federal government, and cash held by the trust funds for investment purposes.
ASSIGNED CLAIM	A claim submitted for a service or supply by a provider who accepts Medicare assignment.

ASSIGNMENT	In the Original Medicare Plan, this means a doctor agrees to accept the Medicare-approved amount as full payment. If you are in the Original Medicare Plan, it can save you money if your doctor accepts assignment. You still pay your share of the cost of the doctor's visit.
ASSISTED LIVING	A type of living arrangement in which personal care services such as meals, housekeeping, transportation, and assistance with activities of daily living are available as needed to people who still live on their own in a residential facility. In most cases, the "assisted living" residents pay a regular monthly rent. Then, they typically pay additional fees for the services they get.
ATTENDING PHYSICIAN	Number of the licensed physician who would normally be expected to certify and recertify the medical necessity of the number of services rendered and/or who has primary responsibility for the patient's medical care and treatment.
AUTHORITATIVE APPROVAL	Method or type of approval that requires a determination that the service is likely to have a diagnostic or therapeutic benefit for patients for whom it is intended.
AUTHORITATIVE EVIDENCE	Written medical or scientific conclusions demonstrating the medical effectiveness of a service produced by the following: Controlled clinical trials, published in peer-reviewed medical or scientific journals; Controlled clinical trials completed and accepted for publication in peer-reviewed medical or scientific journals; Assessments initiated by CMS; Evaluations or studies initiated by Medicare contractors; Case studies published in peer-reviewed medical or scientific journals that present treatment protocols.

AUTHORIZATION	MA approval necessary prior to the receipt of care. (Generally, this is different from a referral in that, an authorization can be a verbal or written approval from the MA whereas a referral is generally a written document that must be received by a doctor before giving care to the beneficiary.)
AUTOMATED CLAIM REVIEW	Claim review and determination made using system logic (edits). Automated claim reviews never require the intervention of a human to make a claim determination.
BALANCE BILLING	A situation in which Private Fee-for-Service Plan providers (doctors or hospitals) can charge and bill you 15% more than the plan's payment amount for services.
BASIC BENEFITS	Basic Benefits includes both Medicare-covered benefits (except hospice services) and additional benefits.
BASIC BENEFITS (MEDIGAP POLICY)	Benefits provided in Medigap Plan A. They are also included in all other standardized Medigap policies. (See Medigap Policy.)
BENEFICIARY	The name for a person who has health care insurance through the Medicare or Medicaid program.
BENEFIT PERIOD	The way that Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you haven't received any hospital care (or skilled care in a SNF) for 60 days in a row. If you go into the hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins if you are in the Original Medicare Plan. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

BENEFITS	The money or services provided by an insurance policy. In a health plan, benefits are the health care you get.
BENEFITS DESCRIPTION (PLAN)	The scope, terms and/or condition(s) of coverage including any limitation(s) associated with the plan provision of the service.
BIOLOGICALS	Usually a drug or vaccine made from a live product and used medically to diagnose, prevent, or treat a medical condition. For example, a flu or pneumonia shot.
BOARD AND CARE HOME	A type of group living arrangement designed to meet the needs of people who cannot live on their own. These homes offer help with some personal care services.
BOARD-CERTIFIED	This means a doctor has special training in a certain area of medicine and has passed an advanced exam in that area of medicine. Both primary care doctors and specialists may be board-certified.
CAPITATION	A specified amount of money paid to a health plan or doctor. This is used to cover the cost of a health plan member's health care services for a certain length of time.
CAPPED RENTAL ITEM	Durable medical equipment (like nebulizers or manual wheelchairs) that costs more than $150, and the supplier rents it to people with Medicare more than 25 percent of the time.
CARE PLAN	A written plan for your care. It tells what services you will get to reach and keep your best physical, mental, and social well being.
CAREGIVER	A person who helps care for someone who is ill, disabled, or aged. Some caregivers are relatives or friends who volunteer their help. Some people provide caregiving services for a cost.

CARRIER	A private company that has a contract with Medicare to pay your Medicare Part B bills. (See Medicare Part B.)
CASE MANAGEMENT	A process used by a doctor, nurse, or other health professional to manage your health care. Case managers make sure that you get needed services, and track your use of facilities and resources.
CASE MANAGER	A nurse, doctor, or social worker who arranges all services that are needed to give proper health care to a patient or group of patients.
CATASTROPHIC ILLNESS	A very serious and costly health problem that could be life threatening or cause life-long disability. The cost of medical services alone for this type of serious condition could cause you financial hardship.
CATASTROPHIC LIMIT	The highest amount of money you have to pay out of your pocket during a certain period of time for certain covered charges. Setting a maximum amount you will have to pay protects you.
CENTERS FOR DISEASE CONTROL AND PREVENTION	An organization that maintains several code sets included in the HIPAA standards, including the ICD-9-CM codes.
CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)	The federal agency that runs the Medicare program. In addition, CMS works with the States to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high quality health care.
CERTIFICATE OF MEDICAL NECESSITY	A form required by Medicare that allows you to use certain durable medical equipment prescribed by your doctor or one of the doctor's office staff.

CERTIFIED (CERTIFICATION)	This means a hospital has passed a survey done by a State government agency. Being certified is not the same as being accredited. Medicare only covers care in hospitals that are certified or accredited.
CERTIFIED NURSING ASSISTANT (CNA)	CNAs are trained and certified to help nurses by providing non-medical assistance to patients, such as help with bathing, dressing, and using the bathroom.
CIVILIAN HEALTH AND MEDICAL PROGRAM (CHAMPUS)	Run by the Department of Defense, in the past CHAMPUS gave medical care to active duty members of the military, military retirees, and their eligible dependents. (This program is now called "TRICARE")
CLAIM	A claim is a request for payment for services and benefits you received. Claims are also called bills for all Part A and Part B services billed through Fiscal Intermediaries. "Claim" is the word used for Part B physician/supplier services billed through the Carrier. (See Carrier; Fiscal Intermediaries; Medicare Part A; Medicare Part B.)
CLAIM ADJUSTMENT REASON CODES	A national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's payment for it. This code set is used in the X12 835 Claim Payment & Remittance Advice and the X12 837 Claim transactions, and is maintained by the Health Care Code Maintenance Committee.
CLAIM ATTACHMENT	Any of a variety of hardcopy forms or electronic records needed to process a claim in addition to the claim itself.
CLINICAL BREAST EXAM	An exam by your doctor/health care provider to check for breast cancer by feeling and looking at your breasts. This exam is not the same as a mammogram and is usually done in the doctor's office during your Pap test and pelvic exam.

CLINICAL PERFORMANCE MEASURE	This is a method or instrument to estimate or monitor the extent to which the actions of a health care practitioner or provider conform to practice guidelines, medical review criteria, or standards of quality.
CLINICAL PRACTICE GUIDELINES	Reports written by experts who have carefully studied whether a treatment works and which patients are most likely to be helped by it.
CLINICAL TRIALS	Clinical trials are one of the final stages of a long and careful research process to help patients live longer, healthier lives. They help doctors and researchers find better ways to prevent, diagnose, or treat diseases. Clinical trials test new types of medical care, like how well a new cancer drug works. The trials help doctors and researchers see if the new care works and if it is safe. They may also be used to compare different treatments for the same condition to see which treatment is better, or to test new uses for treatments already in use.
COGNITIVE IMPAIRMENT	A breakdown in a person's mental state that may affect a person's moods, fears, anxieties, and ability to think clearly.
COHORT	A population group that shares a common property, characteristic, or event, such as a year of birth or year of marriage. The most common one is the birth cohort, a group of individuals born within a defined time period, usually a calendar year or a five-year interval.
COINSURANCE (MEDICARE PRIVATE FEE-FOR-SERVICE PLAN)	The percentage of the Private Fee-for-Service Plan charge for services that you may have to pay after you pay any plan deductibles. In a Private Fee-for-Service Plan, the coinsurance payment is a percentage of the cost of the service (like 20%).
COINSURANCE (OUTPATIENT PROSPECTIVE PAYMENT SYSTEM)	The percentage of the Medicare payment rate or a hospital's billed charge that you have to pay after you pay the deductible for Medicare Part B services.

COMMUNITY MENTAL HEALTH CENTER	A facility that provides the following services: Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharge from inpatient treatment at a mental health facility; 24 hour a day emergency care services; Day treatment, other than partial hospitalization services, or psychosocial rehabilitation services; Screening for patients considered for admission to State mental health facilities to determine the appropriateness of such admission; and Consultation and education services.
COMPLAINT (OF FRAUD OR ABUSE)	A statement, oral or written, alleging that a provider or beneficiary received a Medicare benefit of monetary value, directly or indirectly, overtly or covertly, in cash or in kind, to which he or she is not entitled under current Medicare law, regulations, or policy. Included are allegations of misrepresentation and violations of Medicare requirements applicable to persons or entities that bill for covered items and services.
COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF)	A facility that provides a variety of services including physicians' services, physical therapy, social or psychological services, and outpatient rehabilitation.
CONDITIONAL PAYMENT	A payment made by Medicare for services for which another payer is responsible.
CONSENT AND AUTHORIZATION (BASIC RULE)	A covered entity may use or disclose PHI only: With the consent of the individual for treatment, payment, or health care operations; With the authorization of the individual for all other uses or disclosures; As permitted under this rule for certain public policy purposes.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)*	A law that lets some people keep their employer group health plan coverage for a period of time after: the death of your spouse, losing your job, having your working hours reduced, leaving your job voluntarily, or getting a divorce. You may have to pay both your share and the employer's share of the premium. Generally, you also have to pay an administrative fee.
CONTINUING CARE RETIREMENT COMMUNITY (CCRC)	A housing community that provides different levels of care based on what each resident needs over time. This is sometimes called "life care" and can range from independent living in an apartment to assisted living to full-time care in a nursing home. Residents move from one setting to another based on their needs but continue to live as part of the community. Care in CCRCs is usually expensive. Generally, CCRCs require a large payment before you move in and charge monthly fees.
CONTRACTOR	An entity that has an agreement with CMS or another funding agency to perform a project.
COORDINATION OF BENEFITS	A program that determines which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits. If one of the plans is a Medicare health plan, Federal law may decide who pays first.
COORDINATION PERIOD	A period of time when your employer group health plan will pay first on your health care bills and Medicare will pay second. If your employer group health plan doesn't pay 100% of your health care bills during the coordination period, Medicare may pay the remaining costs.
COST SHARING	The cost for medical care that you pay yourself like a co-payment, coinsurance, or deductible. (See Coinsurance; Co-payment; Deductible.)

COST-BASED HEALTH MAINTENANCE ORGANIZATION	A type of managed care organization that will pay for all of the enrollees/members' medical care costs in return for a monthly premium, plus any applicable deductible or co-payment. The HMO will pay for all hospital costs (generally referred to as Part A) and physician costs (generally referred to as Part B) that it has arranged for and ordered. Like a health care prepayment plan (HCPP), except for out-of-area emergency services, if a Medicare member/enrollee chooses to obtain services that have not been arranged for by the HMO, he/she is liable for any applicable deductible and co-insurance amounts, with the balance to be paid by the regional Medicare intermediary and/or carrier.
COVERED BENEFIT	A health service or item that is included in your health plan, and that is paid for either partially or fully.
COVERED CHARGES	Services or benefits for which a health plan makes either partial or full payment.
CREDITABLE COVERAGE	Any previous health insurance coverage that can be used to shorten the pre-existing condition waiting period. (See Pre-existing Conditions.)
CRITERIA	The expected levels of achievement or specifications against which performance can be assessed.
CRITICAL ACCESS HOSPITAL	A small facility that gives limited outpatient and inpatient hospital services to people in rural areas.
CUSTODIAL CARE	Non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving round, and using the bathroom. It may also include care that most people do themselves, like using eye drops. In most cases, Medicare doesn’t pay for custodial care.

CUSTODIAL CARE FACILITY	A facility, which provides room, board, and other personal assistance services, generally on a long-term basis and which does not include a medical component.
CUSTODIAN	The person responsible for the security and safeguard of CMS data for the duration of the project.
DATE OF FILING AND DATE OF SUBMISSION	The day of the mailing (as evidenced by the postmark) or hand-delivery of materials, unless otherwise defined.
DATE OF RECEIPT	The date on the return receipt of "return receipt requested" mail, unless otherwise defined.
DEDUCTIBLE (MEDICARE)	The amount you must pay for health care before Medicare begins to pay, either for each benefit period for Part A, or each year for Part B. These amounts can change every year. (See Benefit Period; Medicare Part A; Medicare Part B.)
DEEMED	Providers are deemed when they know, before providing services that you are in a Private Fee-for-Service Plan, and they agree to give you care. Providers that are deemed agree to follow your plan's terms and conditions of payment for the services you get.
DEFICIENCY (NURSING HOME)	A finding that a nursing home failed to meet one or more federal or state requirements.
DEMOGRAPHIC DATA	Data that describe the characteristics of enrollee populations within a managed care entity. Demographic data include but are not limited to age, sex, race/ ethnicity, and primary language.
DEPARTMENT OF HEALTH AND HUMAN SERVICES	DHHS administers many of the "social" programs at the Federal level dealing with the health and welfare of the citizens of the United States. (It is the "parent" of CMS.)

DESIGNATED CODE SET	A medical code set or an administrative code set that is required to be used by the adopted implementation specification for a standard transaction.
DETERMINATION	A decision made to either pay in full, pay in part, or deny a claim.
DIABETIC DURABLE MEDICAL EQUIP-MENT	Purchased or rented ambulatory items, such a glucose meters and insulin infusion pumps, prescribed by a health care provider for use in managing a patient's diabetes, as covered by Medicare.
DIAGNOSIS	The name for the health problem that you have.
DIAGNOSIS CODE	The first of these codes is the ICD-9-CM diagnosis code describing the principal diagnosis (i.e. The condition established after study to be chiefly responsible for causing this hospitalization). The remaining codes are the ICD-9-CM diagnosis codes corresponding to additional conditions that coexisted at the time of admission, or developed subsequently, and which had an effect on the treatment received or the length of stay.
DIAGNOSIS-RELATED GROUPS	A classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual.
DIALYSIS	Dialysis is a treatment that cleans your blood when your kidneys don’t work. It gets rid of harmful wastes and extra salt and fluids that build up in your body. It also helps control blood pressure and helps your body keep the right amount of fluids. Dialysis treatments help you feel better and live longer, but they are not a cure for permanent kidney failure

DIALYSIS CENTER (RENAL)	A hospital unit that is approved to furnish the full spectrum of diagnostic, therapeutic, and rehabilitative services required for the care of the ESRD dialysis patients (including inpatient dialysis) furnished directly or under arrangement.
DIALYSIS FACILITY (RENAL)	A unit (hospital based or freestanding) which is approved to furnish dialysis services directly to ESRD patients.
DIALYSIS STATION	A portion of the dialysis patient treatment area which accommodates the equipment necessary to provide a hemodialysis or peritoneal dialysis treatment. This station must have sufficient area to house a chair or bed, the dialysis equipment, and emergency equipment if needed. Provision for privacy is ordinarily supplied by drapes or screens.
DIGITAL IMAGING AND COMMUNICATIONS IN MEDICINE	A standard for communicating images, such as x-rays, in a digitized form. This standard could become part of the HIPAA claim attachments standards.
DISABILITY	For Social Security purposes, the inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or to last for a continuous period of not less than 12 months. Special rules apply for workers aged 55 or older whose disability is based on blindness. The law generally requires that a person be disabled continuously for 5 months before he or she can qualify for a disabled worker cash benefit. An additional 24 months is necessary to qualify under Medicare.
DISABILITY INSURANCE	See "Old-Age, Survivors, and Disability Insurance (OASDI)."
DISABLED ENROLLEE	An individual under age 65 who has been entitled to disability benefits under Title II of the Social Security Act or the Railroad Retirement system for at least 2 years and who is enrolled in the SMI program.

DISCHARGE PLANNING	A process used to decide what a patient needs for a smooth move from one level of care to another. This is done by a social worker or other health care professional. It includes moves from a hospital to a nursing home or to home care. Discharge planning may also include the services of home health agencies to help with the patient's home care.
DISCLOSURE	Release or divulgence of information by an entity to persons or organizations outside of that entity.
DISCLOSURE HISTORY	Under HIPAA this is a list of any entities that have received personally identifiable health care information for uses unrelated to treatment and payment.
DISCOUNT DRUG LIST	A list of certain drugs and their proper dosages. The discount drug list includes the drugs the company will discount.
DISENROLL	Ending your health care coverage with a health plan.
DISPROPORTIONATE SHARE HOSPITAL	A hospital with a disproportionately large share of low -income patients. Under Medicaid, States augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.
DRG CODING	The DRG categories used by hospitals on discharge billing. See also "Diagnosis-related groups (DRGs)."
DRUG TIERS	Drug tiers are definable by the plan. The option “tier” was introduced in the PBP to allow plans the ability to group different drug types together (i.e., Generic, Brand, Preferred Brand). In this regard, tiers could be used to describe drug groups that are based on classes of drugs. If the “tier” option is utilized, plans should provide further clarification on the drug type(s) covered under the tier in the PBP notes section(s). This option was designed to afford users additional flexibility in defining the prescription drug benefit.

DUAL ELIGIBLES	Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.
DURABLE MEDICAL EQUIPMENT	Purchased or rented items such as hospital beds, iron lungs, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a health care provider to be used in a patient's home which are covered by Medicare.
DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER (DMERC)	A private company that contracts with Medicare to pay bills for durable medical equipment.
DURABLE POWER OF ATTORNEY	A legal document that enables you to designate another person, called the attorney-in-fact, to act on your behalf, in the event you become disabled or incapacitated.
ELECTION PERIODS	Time when an eligible person may choose to join or leave the Original Medicare Plan or a Medicare Advantage plan. There are four types of election periods in which you may join and leave Medicare health plans: Annual Election Period, Initial Coverage Election Period, Special Election Period, and Open Enrollment Period.
ELIGIBILITY	Refers to the process whereby an individual is determined to be eligible for health care coverage through the Medicaid program. Eligibility is determined by the State. Eligibility data are collected and managed by the State or by its Fiscal Agent. In some managed care waiver programs, eligibility records are updated by an Enrollment Broker, who assists the individual in choosing a managed care plan to enroll in.

ELIGIBILITY/ MEDICARE PART A	You are eligible for premium-free (no cost) Medicare Part A (Hospital Insurance) if: You are 65 or older and you are receiving, or are eligible for, retirement benefits from Social Security or the Railroad Retirement Board, or You are under 65 and you have received Railroad Retirement disability benefits for the prescribed time and you meet the Social Security Act disability requirements, or You or your spouse had Medicare-covered government employment, or You are under 65 and have End-Stage Renal Disease (ESRD). If you are not eligible for premium-free Medicare Part A, you can buy Part A by paying a monthly premium if: You are age 65 or older, and You are enrolled in Part B, and You are a resident of the United States, and are either a citizen or an alien lawfully admitted for permanent residence who has lived in the United States continuously during the 5 years immediately before the month in which you apply.
ELIGIBILITY/ MEDICARE PART B	You are automatically eligible for Part B if you are eligible for premium-free Part A. You are also eligible for Part B if you are not eligible for premium-free Part A, but are age 65 or older AND a resident of the United States or a citizen or an alien lawfully admitted for permanent residence. In this case, you must have lived in the United States continuously during the 5 years immediately before the month during which you enroll in Part B.

EMERGENCY CARE	Care given for a medical emergency when you believe that your health is in serious danger when every second counts.
EMERGENCY ROOM (HOSPITAL)	A portion of the hospital where emergency diagnosis and treatment of illness or injury is provided.
EMPLOYEE	For purposes of the Medicare Secondary Payer (MSP) provisions, an employee is an individual who works for an employer, whether on a full- or part-time basis, and receives payment for his/her work.
EMPLOYER	Individuals and organizations engaged in a trade or business, plus entities exempt from income tax such as religious, charitable, and educational institutions, the governments of the United States, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and the District of Columbia, and the agencies, instrumentalities, and political subdivisions of these governments.
EMPLOYER GROUP HEALTH PLAN (GHP)	A GHP is a health plan that: Gives health coverage to employees, former employees, and their families, and Is from an employer or employee organization.
END-STAGE RENAL DISEASE (ESRD)	Permanent kidney failure. That stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.
ENROLLMENT PERIOD	A certain period of time when you can join a Medicare health plan if it is open and accepting new Medicare members. If a health plan chooses to be open, it must allow all eligible people with Medicare to join.

ENROLLMENT/ PART A	There are four periods during which you can enroll in premium Part A: Initial Enrollment Period (IEP), General Enrollment Period (GEP), and Special Enrollment Period (SEP). Initial Enrollment Period: The IEP is the first chance you have to enroll in premium Part A. Your IEP starts 3 months before you first meet all the eligibility requirements for Medicare and continues for 7 months. General Enrollment Period: January 1 through March 31 of each year. Your premium Part A coverage is effective July 1 after the GEP in which you enroll. Special Enrollment Period: The SEP is for people who did not take premium Part A during their IEP because you or your spouse currently work and have group health plan coverage through your current employer or union. You can sign up for premium Part A at any time you are covered under the Group Health Plan based on current employment. If the employment or group health coverage ends, you have 8 months to sign up, whichever comes first.
ESRD ELIGIBILITY REQUIREMENTS	To qualify for Medicare under the renal provision, a person must have ESRD and either be entitled to a monthly insurance benefit under Title II of the Act (or an annuity under the Railroad Retirement Act), be fully or currently insured under Social Security (railroad work may count), or be the spouse or dependent child of a person who meets at least one of the two last requirements. There is no minimum age for eligibility under the renal disease provision. An Application for Health Insurance Benefits Under Medicare for Individuals with Chronic Renal Disease, Form HCFA-43 (effective October 1, 1978) must be filed.

EXCESS CHARGES	If you are in the Original Medicare Plan, this is the difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount.
EXCLUSIONS (MEDICARE)	Items or services that Medicare does not cover, such as most prescription drugs, long-term care, and custodial care in a nursing or private home.
EXPEDITED APPEAL	A Medicare Advantage plan organization's second look at whether it will provide a health service. A beneficiary may receive a fast decision within 72 hours when life, health or ability to regain function may be jeopardized.
EXTENDED CARE SERVICES	In the context of this report, an alternate name for "skilled nursing facility services."
EXTERNAL QUALITY REVIEW ORGANIZATION	Is the organization with which the State contracts to evaluate the care provided to Medicaid managed eligibles. Typically the EQRO is a peer review organization. It may conduct focused medical record reviews (i.e. Reviews targeted at a particular clinical condition) or broader analyses on quality. While most EQRO contractors rely on medical records as the primary source of information, they may also use eligibility data and claims/encounter data to conduct specific analyses.
FACILITY CHARGE	Some plans may vary cost shares for services based on place of treatment; in effect, charging a cost for the facility in which the service is received.
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Health centers that have been approved by the government for a program to give low cost health care. Medicare pays for some health services in FQHCs that are not usually covered, like preventive care. FQHCs include community health centers, tribal health clinics, migrant health services, and health centers for the homeless.

FEE SCHEDULE	A complete listing of fees used by health plans to pay doctors or other providers.
FEE-FOR-SERVICES	A plan or PCCM is paid for providing services to enrollees solely through fee-for-service payments plus in most cases, a case management fee.
FISCAL INTERMEDIARY	A private company that has a contract with Medicare to pay Part A and some Part B bills. (Also called "Intermediary.")
FORMULARY	A list of certain drugs and their proper dosages. In some Medicare health plans, doctors must order or use only drugs listed on the health plan's formulary.
FORMULARY DRUGS	Listing of prescription medications which are approved for use and/or coverage by the plan and which will be dispensed through participating pharmacies to covered enrollees.
FRAUD	The intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).
FRAUD AND ABUSE	Fraud: To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced. Abuse: Payment for items or services that are billed by mistake by providers, but should not be paid for by Medicare. This is not the same as fraud.
FREE LOOK (MEDIGAP POLICY)*	A period of time (usually 30 days) when you can try out a Medigap policy. During this time, if you change your mind about keeping the policy, it can be cancelled. If you cancel, you will get your money back.
GAPS	The costs or services that are not covered under the Original Medicare Plan.

GATEKEEPER	In a managed care plan, this is another name for the primary care doctor. This doctor gives you basic medical services and coordinates proper medical care and referrals.
GENERAL ENROLLMENT PERIOD (GEP)	The General Enrollment Period is January 1 through March 31 of each year. If you enroll in Premium Part A or Part B during the General Enrollment Period, your coverage starts on July 1.
GENERIC DRUG	A prescription drug that has the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs.
GRIEVANCE	A complaint about the way your Medicare health plan is giving care. For example, you may file a grievance if you have a problem calling the plan or if you are unhappy with the way a staff person at the plan has behaved toward you. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered (see Appeal).
GRIEVANCES AND COMPLAINTS	Information about grievances and complaints submitted to the health plan.
GROUP HEALTH PLAN	A health plan that provides health coverage to employees, former employees, and their families, and is supported by an employer or employee organization.
GROUP OR NETWORK HMO	An health plan that contracts with group practices of doctors to give services in one or more places.
GUARANTEED ISSUE RIGHTS (ALSO CALLED "MEDIGAP PROTECTIONS")	Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you insurance coverage or place conditions on a policy, must cover you for all pre-existing conditions, and can't charge you more for a policy be-cause of past or present health problems.

GUARANTEED RENEWABLE	A right you have that requires your insurance company to automatically renew or continue your Medigap policy, unless you make untrue statements to the insurance company, commit fraud or don't pay your premiums.
HEALTH CARE PROVIDER	A person who is trained and licensed to give health care. Also, a place that is licensed to give health care. Doctors, nurses, and hospitals are examples of health care providers.
HEALTH CARE QUALITY IMPROVEMENT PROGRAM	HCQIP is a program, which supports the mission of CMS to assure health care security for beneficiaries. The mission of HCQIP is to promote the quality, effectiveness, and efficiency of services to Medicare beneficiaries by strengthening the community of those committed to improving quality, monitoring and improving quality of care, communicating with beneficiaries and health care providers, practitioners, and plans to promote informed health choices, protecting beneficiaries from poor care, and strengthening the infrastructure.
HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)	A law passed in 1996 which is also sometimes called the "Kassebaum-Kennedy" law. This law expands your health care coverage if you have lost your job, or if you move from one job to another, HIPAA protects you and your family if you have: pre-existing medical conditions, and/or problems getting health coverage, and you think it is based on past or present health. HIPAA also: limits how companies can use your pre-existing medical conditions to keep you from getting health insurance coverage; usually gives you credit for health coverage you have had in the past; may give you special help with group health coverage when you lose coverage or have a new dependent; and generally guarantees your right to renew your health coverage. HIPAA does not replace the states' roles as primary regulators of insurance.

HEALTH MAINTENANCE ORGANIZATIONS (HMO)	A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You usually must get your care from the providers in the plan.
HEARING	A procedure that gives a dissatisfied claimant an opportunity to present reasons for the dissatisfaction and to receive a new determination based on the record developed at the hearing. Hearings are provided for in §1842(b)(3)(C) of the Act.
HOME AND COMMUNITY-BASED SERVICE WAIVER PROGRAMS (HCBS)	The HCBS programs offer different choices to some people with Medicaid. If you qualify, you will get care in your home and community so you can stay independent and close to your family and friends. HCBS programs help the elderly and disabled, mentally retarded, developmentally disabled, and certain other disabled adults. These programs give quality and low-cost services.
HOME HEALTH AGENCY	An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.
HOME HEALTH CARE	Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.
HOMEBOUND	Normally unable to leave home unassisted. To be homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious service. A need for adult day care doesn't keep you from getting home health care.

HOSPICE	Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (Hospital Insurance).
HOSPICE CARE	A special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (Hospital Insurance).
HOSPITAL COINSURANCE	For the 61st through 90th day of hospitalization in a benefit period, a daily amount for which the beneficiary is responsible, equal to one-fourth of the inpatient hospital deductible; for lifetime reserve days, a daily amount for which the beneficiary is responsible, equal to one-half of the inpatient hospital deductible (see "Lifetime reserve days").
HOSPITAL INDEMNITY INSURANCE	This kind of insurance pays a certain cash amount for each day you are in the hospital up to a certain number of days. Indemnity insurance doesn't fill gaps in your Medicare coverage.
HOSPITAL INSURANCE	The Medicare program that covers specified inpatient hospital services, post-hospital skilled nursing care, home health services, and hospice care for aged and disabled individuals who meet the eligibility requirements. Also known as Medicare Part A.
HOSPITAL INSURANCE (PART A)	The part of Medicare that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.
HOSPITALIST	A doctor who primarily takes care of patients when they are in the hospital. This doctor will take over your care from your primary doctor when you are in the hospital, keep your primary doctor informed about your progress, and will return you to the care of your primary doctor when you leave the hospital.

IMMUNOSUPPRES-SIVE DRUGS	Transplant drugs used to reduce the risk of rejecting the new kidney after transplant. Transplant patients will need to take these drugs for the rest of their lives.
INITIAL COVERAGE ELECTION PERIOD	The 3 months immediately before you are entitled to Medicare Part A and enrolled in Part B. You may choose a Medicare health plan during your Initial Coverage Election Period. The plan must accept you unless it has reached its limit in the number of members. This limit is approved by the Centers for Medicare & Medicaid Services. The Initial Coverage Election Period is different from the Initial Enrollment Period (IEP). (See Election Periods; Enrollment/Part A; Initial Enrollment Period (IEP).)
INITIAL ENROLLMENT PERIOD	The Initial Enrollment Period is the first chance you have to enroll in Medicare Part B. Your Initial Enrollment Period starts three months before you first meet all the eligibility requirements for Medicare and lasts for seven months.
INPATIENT CARE	Health care that you get when you are admitted to a hospital.
INPATIENT HOSPITAL	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical) and rehabilitation services by or under the supervision of physicians, to patients admitted for a variety of medical conditions.
INPATIENT HOSPITAL DEDUCTIBLE	An amount of money that is deducted from the amount payable by Medicare Part A for inpatient hospital services furnished to a beneficiary during a spell of illness.
INPATIENT HOSPITAL SERVICES	These services include bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.

INPATIENT PSYCHIATRIC FACILITY	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a doctor.
INSOLVENCY	When a health plan has no money or other means to stay open and give health care to patients.
INTEREST	A payment for the use of money during a specified period.
INTERMEDIARY	A private company that has a contract with Medicare to pay Part A and some Part B bills.
INTERMEDIATE CARE FACILITY/MENTALLY RETARDED	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care available in a hospital or skilled nursing facility.
INTERNIST	A doctor who finds and treats health problems in adults.
LARGE GROUP HEALTH PLAN	A group health plan that covers employees of either an employer or employee organization that has 100 or more employees.
LETTER OF REQUEST	A formal request from the requestor on organizational letterhead detailing their data needs and purposes. Additionally, if this project is federally funded a letter of Support is required from the federal Project Officer on their organizational letterhead.
LIABILITY INSURANCE	Liability insurance is insurance that protects against claims for negligence or inappropriate action or inaction, which results in injury to someone or damage to property.
LICENSED (LICENSURE)	This means a long-term care facility has met certain standards set by a State or local government agency.

LIFETIME RESERVE DAYS	In the Original Medicare Plan, 60 days that Medicare will pay for when you are in a hospital more than 90 days during a benefit period. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.
LIMITING CHARGE	In the Original Medicare Plan, the highest amount of money you can be charged for a covered service by doctors and other health care suppliers who don't accept assignment. The limiting charge is 15% over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.
LIVING WILLS	A legal document also known as a medical directive or advance directive. It states your wishes regarding life-support or other medical treatment in certain circumstances, usually when death is imminent.
LONG-TERM CARE	A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare doesn't pay for this type of care if this is the only kind of care you need.
LONG-TERM CARE INSURANCE	A private insurance policy to help pay for some long-term medical and non-medical care, like help with activities of daily living. Because Medicare generally does not pay for long-term care, this type of insurance policy may help provide coverage for long-term care that you may need in the future. Some long-term care insurance policies offer tax benefits; these are called "Tax-Qualified Policies."
LONG-TERM CARE OMBUDSMAN	An advocate (supporter) for nursing home and assisted living facility residents who works to resolve problems between residents and nursing homes or assisted living facilities.

MA PLAN	Health benefits coverage offered under a policy or contract offered by a Medicare Advantage Organization under which a specific set of health benefits are offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the MA plan. See 42 C.F.R. § 422.2. An MA plan may be a coordinated care plan (with or without point of service options), a combination of an MA medical savings account (MSA) plan and a contribution into an MA MSA established in accordance with 42 CFR part 422.262, or an MA private fee-for-service plan. See 42 C.F.R. § 422.4(a).
MANAGED CARE	Includes Health Maintenance Organizations (HMO), Competitive Medical Plans (CMP), and other plans that provide health services on a prepayment basis, which is based either on cost or risk, depending on the type of contract they have with Medicare
MANAGED CARE ORGANIZATION	Managed Care Organizations are entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers. Stands for Managed Care Organization. The term generally includes HMOs, PPOs, and Point of Service plans. In the Medicaid world, other organizations may set up managed care programs to respond to Medicaid managed care. These organizations include Federally Qualified Health Centers, integrated delivery systems, and public health clinics. Is a health maintenance organization, an eligible organization with a contract under §1876 or a Medicare-Choice organization, a provider-sponsored organization, or any other private or public organization, which meets the requirements of §1902 (w) to provide comprehensive services.
MANAGED CARE PLAN	In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extra benefits, like extra days in the hospital. In most cases, a type of Medicare Advantage Plan that is available in some areas of the country. Your costs may be lower than in the Original Medicare Plan.

MANAGED CARE PLAN WITH A POINT OF SERVICE OPTION (POS)	A managed care plan that lets you use doctors and hospitals outside the plan for an additional cost. (See Medicare Managed Care Plan.)
MASS IMMUNIZATION CENTER	A location where providers administer pneumococcal pneumonia and influenza virus vaccination and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as a public health center, pharmacy, or mall but may include a physician's office setting (4408.8, Part 3 of MCM).
MAXIMUM ENROLLEE OUT-OF-POCKET COSTS	The beneficiary's maximum dollar liability amount for a specified period.
MAXIMUM PLAN BENEFIT COVERAGE	The maximum dollar amount per period that a plan will insure. This is only applicable for service categories where there are enhanced benefits being offered by the plan, because Medicare coverage does not allow a Maximum Plan Benefit Coverage expenditure limit.
MEDICAID	A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
MEDICAL INSURANCE (PART B)	Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Part A.
MEDICAL REVIEW/ UTILIZATION REVIEW	Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

MEDICAL UNDERWRITING	The process that an insurance company uses to decide, based on your medical history, whether or not to take your application for insurance, whether or not to add a waiting period for pre-existing conditions (if your State law allows it), and how much to charge you for that insurance.
MEDICALLY NECESSARY	Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.
MEDICARE	The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).
MEDICARE ADVANTAGE PLAN	A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply). Medicare Advantage Plans used to be called Medicare + Choice Plans.
MEDICARE BENEFITS	Health insurance available under Medicare Part A and Part B through the traditional fee-for-service payment system.
MEDICARE BENEFITS NOTICE	A notice you get after your doctor files a claim for Part A services in the Original Medicare Plan. It says what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay. You might also get an Explanation of Medicare Benefits (EOMB) for Part B services or a Medicare Summary Notice (MSN). (See Explanation of Medicare Benefits; Medicare Summary Notice.)
MEDICARE CARRIER	A private company that contracts with Medicare to pay Part B bills.

MEDICARE CONTRACTOR	A Medicare Part A Fiscal Intermediary (institutional), a Medicare Part B Carrier (professional), or a Medicare Durable Medical Equipment Regional Carrier (DMERC)
MEDICARE COORDINATION OF BENEFITS CONTRACTOR	A Medicare contractor who collects and manages information on other types of insurance or coverage that pays before Medicare. Some examples of other types of insurance or coverage are: Group Health Coverage, Retiree Coverage, Workers' Compensation, No-fault or Liability insurance, Veterans' benefits, TRICARE, Federal Black Lung Program, and COBRA.
MEDICARE COVERAGE	Made up of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). (See Medicare Part A (Hospital Insurance); Medicare Part B (Medical Insurance).)
MEDICARE DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER	A Medicare contractor responsible for administering Durable Medical Equipment (DME) benefits for a region.
MEDICARE HANDBOOK	The Medicare Handbook provides information on such things as how to file a claim and what type of care is covered under the Medicare program. This handbook is given to all beneficiaries when first enrolled in the program.
MEDICARE MANAGED CARE PLAN	A type of Medicare Advantage Plan that is available in some areas of the country. In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.
MEDICARE MEDICAL SAVINGS ACCOUNT PLAN (MSA)	A Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help you pay your medical bills.

MEDICARE PART A (HOSPITAL INSURANCE)	Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.
MEDICARE PART A FISCAL INTERMEDIARY	A Medicare contractor that administers the Medicare Part A (institutional) benefits for a given region.
MEDICARE PART B (MEDICAL INSURANCE)	Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Part A.
MEDICARE PART B CARRIER	A Medicare contractor that administers the Medicare Part B (Professional) benefits for a given region.
MEDICARE PRE-FERRED PROVIDER ORGANIZATION (PPO) PLAN	A type of Medicare Advantage Plan in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.
MEDICARE PREMIUM COLLECTION CENTER (MPCC)	The contractor that handles all Medicare direct billing payments for direct billed beneficiaries. MPCC is located in Pittsburgh, Pennsylvania.
MEDICARE PRIVATE FEE-FOR-SERVICE PLAN	A type of Medicare Advantage plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you will get. You may pay more or less for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.
MEDICARE SAVINGS PROGRAM	Medicaid programs that help pay some or all Medicare premiums and deductibles.

MEDICARE SAVINGS PROGRAMS	There are programs that help millions of people with Medicare save money each year. States have programs for people with limited incomes and resources that pay Medicare premiums. Some programs may also pay Medicare deductibles and coinsurance. You can apply for these programs if: You have Medicare Part A (Hospital Insurance). (If you are eligible for Medicare Part A but don't think you can afford it, there is a program that may pay the Medicare Part A premium for you.), you are an individual with resources of $4,000 or less, or are a couple with resources of $6,000 or less. Resources include money in a savings or checking account, stocks, or bonds and You are an individual with limited monthly.
MEDICARE SECONDARY PAYER	Any situation where another payer or insurer pays your medical bills before Medicare.
MEDICARE SELECT	A type of Medigap policy that may require you to use hospitals and, in some cases, doctors within its network to be eligible for full benefits.
MEDICARE SUMMARY NOTICE (MSN)	A notice you get after the doctor or provider files a claim for Part A and Part B services in the Original Medicare Plan. It explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.
MEDICARE SUPPLEMENT INSURANCE	Medicare supplement insurance is a Medigap policy. It is sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Minnesota, Massachusetts, and Wisconsin, there are 12 standardized policies labeled Plan A through Plan L. Medigap policies only work with the Original Medicare Plan. (See Gaps and Medigap Policy.)
MEDICARE-APPROVED AMOUNT	In the Original Medicare Plan, this is the Medicare payment amount for an item or service. This is the amount a doctor or supplier is paid by Medicare and you for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

MEDIGAP POLICY	A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota and Wisconsin, there are 12 standardized plans labeled Plan A through Plan L. Medigap policies only work with the Original Medicare Plan. (See Gaps.)
MILITARY TREATMENT FACILITY	A medical facility operated by one or more of the Uniformed Services. A Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Services (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
MULTI-EMPLOYER GROUP HEALTH PLAN (MULTIPLE EMPLOYER PLAN)	A group health plan that is sponsored jointly by two or more employers or by employers and employee organizations.
NATIONAL HEALTH INFORMATION INFRASTRUCTURE	This is a healthcare-specific lane on the Information Superhighway, as described in the National Information Infrastructure (NII) initiative. Conceptually, this includes the HIPAA A/S initiatives.
NEBULIZERS	Equipment to give medicine in a mist form to your lungs.
NEGLECT	When care takers do not give a person they care for the goods or services needed to avoid harm or illness.
NETWORK	A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members.
NO-FAULT INSURANCE	No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.

NON-COVERED SERVICE	The service: does not meet the requirements of a Medicare benefit category, is statutorily excluded from coverage on ground other than 1862(a)(1), or is not reasonable and necessary under 1862 (a)(1).
NON-FORMULARY DRUGS	Drugs not on a plan-approved list.
NONPARTICIPATING PHYSICIAN	A doctor or supplier who does not accept assignment on all Medicare claims.
NURSE PRACTITIONER	A nurse who has 2 or more years of advanced training and has passed a special exam. A nurse practitioner often works with a doctor and can do some of the same things a doctor does.
NURSING FACILITY	A facility which primarily provides to residents skilled nursing care and relate services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.
NURSING HOME	A residence that provides a room, meals, and help with activities of daily living and recreation. Generally, nursing home residents have physical or mental problems that keep them from living on their own. They usually require daily assistance.
OCCUPATIONAL THERAPY	Services given to help you return to usual activities (such as bathing, preparing meals, housekeeping) after illness.
OFFICE	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE	The Social Security programs that pay for (1) monthly cash benefits to retired-worker (old-age) beneficiaries, their spouses and children, and survivors of deceased insured workers (OASI); and (2) monthly cash benefits to disabled-worker beneficiaries and their spouses and children, and for providing rehabilitation services to the disabled (DI).
OMBUDSMAN	An ombudsman is an individual who assists enrollees in resolving problems they may have with their MCO/PHP. An ombudsman is a neutral party who works with the enrollee, the MCO/PHP, and the provider (as appropriate) to resolve individual enrollee problems.
OPEN ENROLLMENT PERIOD	A one-time-only six month period when you can buy any Medigap policy you want that is sold in your State. It starts in the first month that you are covered under Medicare Part B and you are age 65 or older. During this period, you can?t be denied coverage or charged more due to past or present health problems.
ORIGINAL MEDICARE PLAN	A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). In some cases you may be charged more than the Medicare-approved amount. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).
OUT OF NETWORK BENEFIT	Generally, an out-of-network benefit provides a beneficiary with the option to access plan services outside of the plans contracted network of providers. In some cases, a beneficiary’s out-of-pocket costs may be higher for an out-of-network benefit.
OUT-OF-POCKET COSTS	Health care costs that you must pay on your own because they are not covered by Medicare or other insurance.

OUTPATIENT CARE	Medical or surgical care that does not include an overnight hospital stay.
OUTPATIENT HOSPITAL	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. Part of the Hospital providing services covered by SMI, including services in an emergency room or outpatient clinic, ambulatory surgical procedures, medical supplies such as splints, laboratory tests billed by the hospital, etc.
OUTPATIENT HOSPITAL SERVICES (MEDICARE)	Medicare or surgical care that Medicare Part B helps pay for and does not include an overnight hospital stay, including: blood transfusions; certain drugs; hospital billed laboratory tests; mental health care; medical supplies such as splints and casts; emergency room or outpatient clinic, including same day surgery; and x-rays and other radiation services.
OUTPATIENT SERVICES	A service you get in one day (24 hours) at a hospital outpatient department or community mental health center.
PAP TEST	A test to check for cancer of the cervix, the opening to a woman's womb. It is done by removing cells from the cervix. The cells are then prepared so they can be seen under a microscope.
PART A (HOSPITAL INSURANCE)	Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

PART A OF MEDICARE	Medicare Hospital Insurance also referred to as "HI." Part A is the hospital insurance portion of Medicare. It was established by §1811 of Title XVIII of the Social Security Act of 1965, as amended, and covers inpatient hospital care, skilled nursing facility care, some home health agency services, and hospice care.
PART A PREMIUM	A monthly premium paid by or on behalf of individuals who wish for and are entitled to voluntary enrollment in the Medicare HI program. These individuals are those who are aged 65 and older, are uninsured for social security or railroad retirement, and do not otherwise meet the requirements for entitlement to Part A. Disabled individuals who have exhausted other entitlement are also qualified. These individuals are those not now entitled but who have been entitled under section 226(b) of the Act, who continue to have the disabling impairment upon which their entitlement was based, and whose entitlement ended solely because the individuals had earnings that exceeded the substantial gainful activity amount (as defined in section 223(d)(4) of the Act).
PART B (MEDICAL INSURANCE)	Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that aren't covered by Part A.
PART B (MEDICARE)	Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A. (See Medical Insurance (Part B).)
PART B OF MEDICARE	Medicare Supplementary Medical Insurance also referred to as "SMI." Medicare insurance that pays for inpatient hospital stay, care in a skilled nursing facility, home health care, and hospice care. Part B is the supplementary or "physicians" insurance portion of Medicare. It was established by 1831 of the Title XVIII of the Social Security Act of 1965 as amended, and covers services of physicians/other suppliers, outpatient care, medical equipment and supplies, and other medical services not covered by the hospital insurance part of Medicare.

PARTICIPATING HOSPITALS	Those hospitals that participate in the Medicare program.
PARTICIPATING PHYSICIAN OR SUPPLIER	A doctor or supplier who agrees to accept assignment on all Medicare claims. These doctors or suppliers may bill you only for Medicare deductible and/or coinsurance amounts.
PATIENT ADVOCATE	A hospital employee whose job is to speak on a patient's behalf and help patients get any information or services they need.
PAYER	In health care, an entity that assumes the risk of paying for medical treatments. This can be an uninsured patient, a self-insured employer, a health plan, or an HMO.
PELVIC EXAM	An exam to check if internal female organs are normal by feeling their shape and size.
PERIODS OF CARE (HOSPICE)	A set period of time that you can get hospice care after your doctor says that you are eligible and still needs hospice care.
PERSONAL CARE	Non-skilled, personal care, such as help with activities of daily living like bathing, dressing, eating, getting in and out of bed or chair, moving around, and using the bathroom. It may also include care that most people do themselves, like using eye drops. The Medicare home health benefit does pay for personal care services.
PHYSICAL THERAPY	Treatment of injury and disease by mechanical means, such as heat, light, exercise, and massage.
PHYSICIAN ASSISTANT (PA)	A person who has 2 or more years of advanced training and has passed a special exam. A physician assistant works with a doctor and can do some of the things a doctor does.

PHYSICIAN GROUP	A partnership, association, corporation, individual practice association (IPA), or other group that distributes income from the practice among members. An IPA is considered to be a physician group only if it is composed of individual physicians and has no subcontracts with other physician groups.
PHYSICIAN SERVICES	Services provided by an individual licensed under state law to practice medicine or osteopathy. Physician services given while in the hospital that appear on the hospital bill are not included.
PLAN OF CARE	Your doctor's written plan saying what kind of services and care you need for your health problem.
POINT OF SERVICE (POS)	An additional, mandatory supplemental, or optional supplemental benefit that allows the enrollee the option of receiving specified services outside of the plan's provider network.
POWER OF ATTORNEY	A medical power of attorney is a document that lets you appoint someone you trust to make decisions about your medical care. This type of advance directive also may be called a health care proxy, appointment of health care agent or a durable power of attorney for health care.
PRE-EXISTING CONDITION	A health problem you had before the date that a new insurance policy starts.
PREFERRED PROVIDER ORGANIZATION (PPO)	A managed care in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

PREMIUM SURCHARGE	The standard Medicare Part B premium will go up ten percent for each full 12-month period (beginning with the first month after the end of your Initial Enrollment Period) that you could have had Medicare Part B but didn't take it. The additional premium amount is called a "premium surcharge." There will be a surcharge for Part D also.
PREVENTIVE SERVICES	Health care to keep you healthy or to prevent illness (for example, Pap tests, pelvic exams, flu shots, and screening mammograms).
PRIMARY CARE	A basic level of care usually given by doctors who work with general and family medicine, internal medicine (internists), pregnant women (obstetricians), and children (pediatricians). A nurse practitioner (NP), a State licensed registered nurse with special training, can also provide this basic level of health care.
PRIMARY CARE DOCTOR	A doctor who is trained to give you basic care. Your primary care doctor is the doctor you see first for most health problems. He or she makes sure that you get the care that you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare managed care plans, you must see your primary care doctor before you see any other health care provider.
PRIMARY PAYER	An insurance policy, plan, or program that pays first on a claim for medical care. This could be Medicare or other health insurance.
PRIVACY ACT OF 1974	Without the written consent of the individual, the Privacy Act prohibits release of protected information maintained in a system of records unless of 1 of the 12 disclosure provisions apply.

PRIVATE CONTRACT	A contract between you and a doctor, podiatrist, dentist, or optometrist who has decided not to offer services through the Medicare program. This doctor can't bill Medicare for any service or supplies given to you and all his/her other Medicare patients for at least 2 years. There are no limits on what you can be charged for services under a private contract. You must pay the full amount of the bill.
PRIVATE FEE-FOR-SERVICE PLAN	A type of Medicare Advantage Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it pays and what you pay for the services you will get. You may pay more or less for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.
PROCEDURE	Something done to fix a health problem or to learn more about it. For example, surgery, tests, and putting in an IV (intravenous line) are procedures.
PROGRAMS OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)	PACE combines medical, social, and long-term care services for frail people. PACE is available only in states that have chosen to offer it under Medicaid. To be eligible, you must: Be 55 years old, or older, Live in the service area of the PACE program, Be certified as eligible for nursing home care by the appropriate state agency , and Be able to live safely in the community. The goal of PACE is to help people stay independent and live in their community as long as possible, while getting high quality care they need.
PROSPECTIVE PAYMENT SYSTEM	A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services).

PROVIDER	Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing medical services covered under Medicare Part B. Any organization, institution, or individual that provides health care services to Medicare beneficiaries. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of services covered under Medicare Part B.
PROVIDER NETWORK	The providers with which an M+C Organization contracts or makes arrangements to furnish covered health care services to Medicare enrollees under an M+C coordinated care or network MSA plan.
PROVIDER SPONSORED ORGANIZATION (PSO)	A group of doctors, hospitals, and other health care providers that agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. This type of managed care plan is run by the doctors and providers themselves, and not by an insurance company. (See Managed Care Plan.)
PSYCHIATRIC FACILITY (PARTIAL HOSPITALIZATION)	Partial hospitalization (location 52) is a program in which a patient attends for several hours during the day (example: 8:30-3:30) the patient is not there on a 24 hours basis.
PSYCHIATRIC RESIDENTIAL TREATMENT CENTER	A facility or distinct part of a facility for psychiatric care that provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
QUALIFIED MEDICARE BENEFICIARY (QMB)	This is a Medicaid program for beneficiaries who need help in paying for Medicare services. The beneficiary must have Medicare Part A and limited income and resources. For those who qualify, the Medicaid program pays Medicare Part A premiums, Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare services.

QUALIFYING INDIVIDUALS (1) (QI-1S)	This is a Medicaid program for beneficiaries who need help in paying for Medicare Part B premiums. The beneficiary must have Medicare Part A and limited income and resources and not be otherwise eligible for Medicaid. For those who qualify, the Medicaid program pays full Medicare Part B premiums only.
QUALIFYING INDIVIDUALS (2) (QI-2S)	This is a Medicaid program for beneficiaries who need help in paying for Medicare Part B premiums. The beneficiary must have Medicare Part A and limited income and resources and not be otherwise eligible for Medicaid. For those who qualify, Medicaid pays a percentage of Medicare Part B premiums only.
QUALITY ASSURANCE	The process of looking at how well a medical service is provided. The process may include formally reviewing health care given to a person, or group of persons, locating the problem, correcting the problem, and then checking to see if what you did worked.
QUALITY IMPROVEMENT ORGANIZATION	Groups of practicing doctors and other health care experts. They are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by: inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for Service plans, and ambulatory surgical centers.
RAILROAD RETIREMENT	A federal insurance program similar to Social Security designed for workers in the railroad industry. The provisions of the Railroad Retirement Act provide for a system of coordination and financial interchange between the Railroad Retirement program and the Social Security program.

REASONABLE COST	FIs and carriers use CMS guidelines to determine reasonable costs incurred by individual providers in furnishing covered services to enrollees. Reasonable cost is based on the actual cost of providing such services, including direct and indirect cost of providers and excluding any costs that are unnecessary in the efficient delivery of services covered by the program.
RECIPIENT	An individual covered by the Medicaid program, however, now referred to as a beneficiary.
RECOUPMENT	The recovery by Medicare of any Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness.
REFERRAL	A written OK from your primary care doctor for you to see a specialist or get certain services. In many Medicare Managed Care Plans, you need to get a referral before you can get care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for your care.
REFERRAL	A plan may restrict certain health care services to an enrollee unless the enrollee receives a referral from a plan-approved caregiver, on paper, referring them to a specific place/person for the service. Generally, a referral is defined as an actual document obtained from a provider in order for the beneficiary to receive additional services.
REGIONAL HOME HEALTH INTERMEDIARY (RHHI)	A private company that contracts with Medicare to pay home health bills and check on the quality of home health care.
REHABILITATION	Rehabilitative services are ordered by your doctor to help you recover from an illness or injury. These services are given by nurses and physical, occupational, and speech therapists. Examples include working with a physical therapist to help you walk and with an occupational therapist to help you get dressed.

REHABILITATION (AS DISTINGUISHED FROM VOCATIONAL REHABILITATION)	A restorative process through which an individual with ESRD develops and maintains self-sufficient functioning consistent with his/her capability.
RESERVE DAYS	(See Lifetime Reserve Days.)
RESPITE CARE	Temporary or periodic care provided in a nursing home, assisted living residence, or other type of long-term care program so that the usual caregiver can rest or take some time off.
RIGHTS OF INDIVIDUALS	Receive notice of information practices; See and copy own records; Request corrections; Obtain accounting of disclosures; Request restrictions and confidential communications; File complaints
RISK-BASED HEALTH MAINTENANCE ORGANIZATION/ COMPETITIVE MEDICAL PLAN	A type of managed care organization. After any applicable deductible or co-payment, all of an enrollee/ member's medical care costs are paid for in return for a monthly premium. However, due to the "lock-in" provision, all of the enrollee/member's services (except for out-of-area emergency services) must be arranged for by the risk-HMO. Should the Medicare enrollee/ member choose to obtain service not arranged for by the plan, he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for services from providers that are not part of the HMO's health care system/network.
RURAL HEALTH CLINIC	An outpatient facility that is primarily engaged in furnishing physicians' and other medical and health services and that meets other requirements designated to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically underserved area that is not urbanized as defined by the U.S. Bureau of Census.

SANCTIONS	Administrative remedies and actions (e.g., exclusion, Civil Monetary Penalties, etc.) available to the OIG to deal with questionable, improper, or abusive behaviors of providers under the Medicare, Medicaid, or any State health programs.
SECOND OPINION	This is when another doctor gives his or her view about what you have and how it should be treated.
SECONDARY PAYER	An insurance policy, plan, or program that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the situation.
SELF-INSURED	An individual or organization that assumes the financial risk of paying for health care.
SERVICE	Medical care and items such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital RPCH or SNF facilities. (42 CFR 400.202).
SERVICE AREA	The area where a health plan accepts members. For plans that require you to use their doctors and hospitals, it is also the area where services are provided. The plan may disenroll you if you move out of the plan's service area.
SERVICE AREA (PRIVATE FEE-FOR-SERVICE)	The area where a Medicare Private Fee-for-Service plan accepts members.
SIDE EFFECT	A problem caused by treatment. For example, medicine you take for high blood pressure may make you feel sleepy. Most treatments have side effects.

SKILLED CARE	A type of health care given when you need skilled nursing or rehabilitation staff to manage, observe, and evaluate your care.
SKILLED NURSING CARE	A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).
SKILLED NURSING FACILITY (SNF)	A facility (which meets specific regulatory certification requirements) which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
SKILLED NURSING FACILITY CARE	This is a level of care that requires the daily involvement of skilled nursing or rehabilitation staff. Examples of skilled nursing facility care include intravenous injections and physical therapy. The need for custodial care (for example, assistance with activities of daily living, like bathing and dressing) cannot, in itself, qualify you for Medicare coverage in a skilled nursing facility. However, if you qualify for coverage based on your need for skilled nursing or rehabilitation, Medicare will cover all of your care needs in the facility, including assistance with activities of daily living.
SNF COINSURANCE	For the 21st through 100th day of extended care services in a benefit period, a daily amount for which the beneficiary is responsible, equal to one-eighth of the inpatient hospital deductible.
SPECIAL ELECTION PERIOD	A set time that a beneficiary can change health plans or return to the Original Medicare Plan, such as: you move outside the service area, your Medicare Advantage organization violates its contract with you, the organization does not renew its contract with CMS, or other exceptional conditions determined by CMS. The Special Election Period is different from the Special Enrollment Period (SEP). (See Election Periods; Enrollment; Special Enrollment Period (SEP).)

SPECIALIST	A doctor who treats only certain parts of the body, certain health problems, or certain age groups. For example, some doctors treat only heart problems.
SPECIALTY PLAN	A type of Medicare Advantage Plan that provides more focused health care for some people. These plans give you all your Medicare health care as well as more focused care to manage a disease or condition such as congestive heart failure, diabetes, or End-Stage Renal Disease.
SPECIFIED DISEASE INSURANCE	This kind of insurance pays benefits for only a single disease, such as cancer, or for a group of diseases. Specified Disease Insurance doesn't fill gaps in your Medicare coverage.
SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLMB)	A Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources.
SPEECH-LANGUAGE THERAPY	Treatment to regain and strengthen speech skills.
STATE INSURANCE DEPARTMENT	A state agency that regulates insurance and can provide information about Medigap policies and any insurance related problem.
STATE OR LOCAL PUBLIC HEALTH CLINIC	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
SUBSIDIZED SENIOR HOUSING	A type of program, available through the Federal Department of Housing and Urban Development and some States, to help people with low or moderate incomes pay for housing.

SUPPLEMENTARY MEDICAL INSURANCE	The Medicare program that pays for a portion of the costs of physicians' services, outpatient hospital services, and other related medical and health services for voluntarily insured aged and disabled individuals. Also known as Part B.
SUPPLIER	Generally, any company, person, or agency that gives you a medical item or service, like a wheelchair or walker.
TERM INSURANCE	A type of insurance that is in force for a specified period of time.
THIRD PARTY ADMINISTRATOR	An entity required to make or responsible for making payment on behalf of a group health plan.
TRANSIENT PATIENTS	Patients who receive treatments on an episodic basis and are not part of a facilities regular caseload (i.e. patients who have not been permanently transferred to a facility for ongoing treatments).
TREATMENT	Something done to help with a health problem. For example, medicine and surgery are treatments.
TREATMENT OPTIONS	The choices you have when there is more than one way to treat your health problem.
TRICARE	A health care program for active duty and retired uniformed services members and their families.
TRICARE FOR LIFE (TFL)	Expanded medical coverage available to Medicare-eligible uniformed services retirees age 65 or older, their eligible family members and survivors, and certain former spouses.

TTY	A teletypewriter (TTY) is a communication device used by people who are deaf, hard of hearing, or have a severe-speech impairment. A TTY consists of a keyboard, display screen, and modem. Messages travel over regular telephone lines. People who don?t have a TTY can communicate with a TTY user through a message relay center (MRC). An MRC has TTY operators available to send and interpret TTY messages.
UNASSIGNED CLAIM	A claim submitted for a service or supply by a provider who does not accept assignment.
URGENTLY NEEDED CARE	Care that you get for a sudden illness or injury that needs medical care right away, but is not life threatening. Your primary care doctor generally provides urgently needed care if you are in a Medicare health plan other than the Original Medicare Plan. If you are out of your plan's service area for a short time and cannot wait until you return home, the health plan must pay for urgently needed care.
VOCATIONAL REHABILITATION	The process of facilitating an individual in the choice of or return to a suitable vocation. When necessary, assisting the patient to obtain training for such a vocation. Vocational rehabilitation can also mean to preparing an individual regardless of age, status (whether U.S. citizen or immigrant) or physical condition (disability other than ESRD) to cope emotionally, psychologically, and physically with changing circumstances in life, including remaining at school or returning to school, work, or work equivalent (homemaker).
WAITING PERIOD	The time between when you sign up with a Medigap insurance company or Medicare health plan and when the coverage starts.
WORKERS COMPENSATION	Insurance that employers are required to have to cover employees who get sick or injured on the job.